

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03434

03431

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 Cherryway		d. STREET ADDRESS R.D.# 3 Cherryway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle REED	Last BARTLETT
4. DATE OF DEATH	Month March	Day 9	Year th 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1876
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Day 20	12. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Conductor-Railroading		11. BIRTHPLACE (State or foreign country) Tilghmans Island Md.	
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Charles Bartlett		14. MOTHER'S MAIDEN NAME (Uhk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Doris Brittingham (Niece) R.D.# 3 Cherryway Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident with hemiplegia R. DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertension essential and hypertensive heart DUE TO			
(c) Arteriosclerosis, arteriosclerotic heart disease DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 12, 1957, to March 1957, that I last saw the deceased alive on Mar 8, 1957, and that death occurred at 9:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. 303 East St. (Office) Mar. 1957			
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler M.D.		Delmar, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D. BY REGISTRAR DATE MAR 11 1957	
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED IN THE STATE OF HAWAII

BUREAU A. M.

MAR 11 1957

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472 CERTIFICATE OF DEATH

03435
337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Levin	Middle Thomas	Last Beach
4. DATE OF DEATH	Month March	Day 30	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1872
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Sussex County, Del.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Levin Handy Beach	14. MOTHER'S MAIDEN NAME Amanda Bradley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Vernen Beach, Mardela, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Enterovirus Hand Foot INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute cholangitis & common duct stone 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/1 , 19 57 to death , 19 57 , that I last saw the deceased alive on 3/28 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Grove St, Delmar, Del. DATE SIGNED 4/4/57			
ACTUAL SIGNATURE <i>Ernest M. Larmore</i>	PHYSICIAN'S NAME (Type) ERNEST M. LARMORE		
22a. BURIAL, CREMATION, (Specify) Burial	22b. DATE THEREOF 4-2-1957	22c. NAME OF CEMETERY OR Crematory Beach	22d. LOCATION (City, town, or county) Mardela, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Mason - Shadytown Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 3 1957	24b. REGISTRAR'S SIGNATURE <i>May H. Holloway</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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RECEIVED
APR 3 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03432

CERTIFICATE OF DEATH

03436
338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb <i>30 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12 Salisbury</i>		d. STREET ADDRESS <i>715 Delaware Ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula Gen Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Alice</i>		First <i>A.</i>	Middle <i>G.</i>	Last <i>Brown</i>	4. DATE OF DEATH <i>3</i>	Month <i>1</i>	Day <i>1</i>	Year <i>1957</i>
5. SEX <i>F.M.</i>		6. COLOR OR RACE <i>A.A.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-4-1884</i>		9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House Work</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Fred Garfield</i>		14. MOTHER'S MAIDEN NAME <i>Mary Shelby</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>260X</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Claude Robinson, Route #2, Salisbury, Md</i>		Address <i>—</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i>		DUE TO <i>Generalized Arteriosclerosis</i>		DUE TO <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 month</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		(b)		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on <i>12/2/57</i> , and that death occurred at <i>9:30 A.M.</i> on <i>12/2/57</i> , that I last saw the deceased ADDRESS (Street, city or town, state) <i>652 W Main, Salisbury, Md</i>		DATE SIGNED <i>12/2/57</i>						
ACTUAL SIGNATURE <i>F. A. Purnell</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>F. A. Purnell</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-5-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>GREEN ACRES Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Salisbury, Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart Funeral Home, Salisbury, Md</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>6</i>		24b. REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>		
VS A15 (4) 15M 9/55				DATE <i>6 1957</i>				

CEMETECALE DE GEAUA

BUREAU V. G.

MAR 6 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03437

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Wicomico	MARYLAND	MARYLAND
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)		STATE Maryland
TOWN	16 yrs		COUNTY Wicomico
HOSPITAL OR INSTITUTION OR STREET ADDRESS	John B. Parsons Home for Aged		CITY (If outside corporate limits, write RURAL and give nearest town)
90		12	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Anthony Brown		Mary E. Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)		Records: John B. Parsons Home	
		Salisbury, Maryland	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442 X IMMEDIATE CAUSE (A) <i>Cardiovascular renal disease</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1957, to 3-26, 1957, that I last saw the deceased alive on 3-26, 1957, and that death occurred at 4:00A.M. from the causes and on the date stated above.			
SIGNATURE <i>Philip A. Insley</i> ADDRESS (Street, city, town, state) DATE SIGNED			
Dr. Philip A. Insley M.D. E. Main St. Salisbury, Maryland Mar. 28 / 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 28, 1957	
NAME OF CEMETERY OR CREMATORIUM Smullen Cemetery		LOCATION (City, town, or county) Worcester Co. Maryland	
24. REC'D BY REGISTRAR APR 1 1957		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	
		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND	

CERTIFICATE OF DATA

GENERAL STATE OF CALIFORNIA - OFFICE OF THE ATTORNEY GENERAL

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03438

03473

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		c. LENGTH OF STAY IN 1b app: 15yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1 (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
3. NAME OF DECEASED (Type or print) ADDIE		4. DATE OF DEATH MARCH 5th 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 25, 1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Rogersville, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Res. no. or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Byras V. Cook (Son) R.D. # 1 (Rural) Quantico, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5th</u> , 1957, to <u>March 5th</u> , 1957, that I last saw the deceased alive on <u>March 5th</u> , 1957, and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William Emrich</u>		ADDRESS (Street, city or town, state) DATE SIGNED M.D. Main St. (Office) March 5th 1957	
PHYSICIAN'S NAME (Type) Dr. William Emrich		M.D. Hebron, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 8, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE MAR 8 1957	
		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

此页仅限于非商业用途，不得用于任何商业目的。

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9 Film G-12 3-20-57 et

03439

03431

CERTIFICATE OF DEATH

Reg. Dist. No. 332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Vernon			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 732 Jackson St., Private Home		d. STREET ADDRESS Rt. #3 (Princess Ann)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLYDE		First MIDDLE MARTIN	LAST COSTEN	4. DATE OF DEATH 3	Month 5	Day 19	Year 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 22, 1887	9. AGE (In years last birthday) 67 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry T. Costen		14. MOTHER'S MAIDEN NAME Lula Brewington		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph Lappin, Same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma Lungs Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH Ten days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-5, 1957, to 3-5, 1957 that I last saw the deceased alive on 3-5, 1957, and that death occurred at 3:15 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Wilmer R. Ellis, Jr. PHYSICIAN'S NAME (Type) Wilmer R. Ellis, Jr., M.D.		ADDRESS (Street, city or town, state) Medical Center, Salisbury, Md. DATE SIGNED 3/6/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/57		22c. NAME OF CEMETERY OR CREMATORIAL Grace Episcopal Cemetery		22d. LOCATION (City, town, or county) Mt. Vernon, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker		24a. REC'D BY REGISTRAR DATE 3-7-57		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. 2

MAR 11 1957

REGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03474

CERTIFICATE OF DEATH

03440

332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION X		d. STREET ADDRESS XXX	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEVIN		4. DATE OF DEATH March 7 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1870	
9. AGE (In years from birth) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Davis		14. MOTHER'S MAIDEN NAME Mary Godfrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X	
17. INFORMANT Mr. Elmer C. Davis		Address Willards, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 70 minutes	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7, 1957, to 3-7, 1957, that I last saw the deceased alive on 3-7, 1957, and that death occurred at 1 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Willards Maryland DATE SIGNED			
ACTUAL SIGNATURE Frank Lewis		M.D.	
PHYSICIAN'S NAME (Type) FRANK L. LEWIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/57	
22c. NAME OF CEMETERY OR CREMATORIUM Dennis		22d. LOCATION (City, town, or county) Willards Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Sellyville Md.		24a. REC'D BY REGISTRAR MAR 1 1957	
		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. L.

MAR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film C213 1-1-57 et

CERTIFICATE OF DEATH

03441
337

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Salisbury General Hospital

3. NAME OF DECEASED (Type or print)

Robert

First

Middle

Last

4. DATE OF DEATH

MAY 1 1957

Month

Day

Year

5. SEX

MALE

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

APRIL 7, 1987

9. AGE (In years lost birthday)

69 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

OWN FARM

11. BIRTHPLACE (State or foreign country)

BISHOP, MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hiram Burton Davis

14. MOTHER'S MAIDEN NAME

ANNIE K. BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

221-12-0271

17. INFORMANT

Mr. M. P. DAVIS

Address

Berlin, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

Coronary artery heart disease

INTERVAL BETWEEN ONSET AND DEATH

1-17

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Coronary artery disease

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m.20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3-21, 1957, to 3-24, 1957, that I last saw the deceased alive on 3-24-57, 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

M.D.

Salisbury, Md. May 1 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

3/27/57

22c. NAME OF CEMETERY OR CREMATORIAL

ODD FELLOWS

22d. LOCATION (City, town, or county)

(State)

BISHOPVILLE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John S. Quisenberry Berlin, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Mary F. Hallaway

BUREAU X.

MAR 27 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

03475

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>404 East Street</u>			d. STREET ADDRESS <u>5th Avenue</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>William</u>	Middle <u>Brewster</u>	Last <u>Deen</u>	4. DATE OF DEATH	Month <u>March</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 20, 1882</u>	9. AGE (In years last birthday) <u>74</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (G ve-kind of work done during most of working life, even if retired) <u>Attorney at Law</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Deen</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Willis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Victoria D. Butler, Delmar, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH: <u>10 day.</u>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			Cerebral thrombosis L. hemisphere Cerebral and generalized asthenesclerosis		
DUE TO (b)			?		
DUE TO (c)					
PART II. OTHER, SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Skin Cancer L. lower eyelid.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY	Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Federalsburg</u>	(County) <u>Maryland</u> (State)
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>March 12, 1957</u> that I last saw the deceased alive on <u>March 1, 1957</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>L. H. Schler</u>	M.D.			ADDRESS (Street, city or town, state) <u>302 East Street, Delmar</u>	
PHYSICIAN'S NAME (Type) <u>L. H. Schler</u>				DATE SIGNED <u>3-14-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>March 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Hill Crest Cemetery</u>	22d. LOCATION (City, town, or county) <u>Federalsburg, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fremptom and Son, Federalsburg, Maryland</u>			24a. REC'D BY REGISTRAR <u>3-23-57</u>	24b. REGISTRAR'S SIGNATURE <u>Marjorie W. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU Y. S.

MR 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03443

Reg. Dist. No. 33 ✓

03476

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Willards		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Willards	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St		d. STREET ADDRESS Main St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAWRENCE		First GRANT	Middle DENNIS
4. DATE OF DEATH March 26th 1957		Month March	Day 26th
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 9, 1903
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 2 Days 11 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Willards Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Dennis		14. MOTHER'S MAIDEN NAME Bettie Burbage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Bessie D. Dennis (Wife) Main St. Willards, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of heart 176 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound.	
20c. TIME OF INJURY Hour 12:30 P.M. Month, Day, Year 3-26-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage at home.		20f. (City or town) Willards	
		(County) Wicomico	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED Mar. 28 1957	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM DENNIS FAMILY CEMETERY		22d. LOCATION (City, town, or county) Willards, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR R. 691-51	
		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	

BUREAU X.

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03444

03477 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b In Village		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		d. STREET ADDRESS In Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARTHA	Middle EMILY	Last DERICKSON
4. DATE OF DEATH	Month MARCH	Day 20 th	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1898
9. AGE (in years lost birthday) 58 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pittsville, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Allison T. Smith	14. MOTHER'S MAIDEN NAME Annie Elliott		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. William H. Derickson (Husband) Parsonsburg, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 415 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH Years	
(b) Rheumatic heart disease DUE TO (c)		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 34, 1957, to 3-20-7, 1957, that I last saw the deceased alive on 3-19-57 1957, and that death occurred at A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Earl L. Royer</i> M.D. ADDRESS (Street, city or town, state) Camden Ave. (Office) DATE SIGNED March 21 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 22, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Parsonsburg Cemetery	22d. LOCATION (City, town, or county) Parsonsburg, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR MAR 26 1957	
		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	

RECEIVED
MAR 26 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03436

CERTIFICATE OF DEATH

03445

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Salisbury		c. LENGTH OF STAY IN 1b 46 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. STREET ADDRESS W. Main Street	
3. NAME OF DECEASED (Type or print) Ira Dorman		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 11 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Crisfield, Md.
13. FATHER'S NAME Severn Dize		14. MOTHER'S MAIDEN NAME Mary Dorman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records
		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days ? ?	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 31, 1957, to March 18, 1957, that I last saw the deceased alive on March 18, 1957, and that death occurred at 10:55A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Andres Grisolia, M.D. Physician's Name (Type) Andres Grisolia, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/57	22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. Grisolia, Esq.		24a. ADDRESS for Breton Funeral Home ADDRESS 3-26157	24b. REGISTRAR'S SIGNATURE Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as a burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

MAR 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03478

03446

CERTIFICATE OF DEATH

Reg. Dist. No. 832

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b 60 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMA		First	Middle	Last	4. DATE OF DEATH 3 24 1957	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 2, 1865	9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George W. Cathell		14. MOTHER'S MAIDEN NAME Mary Jane Carey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Ralph O. Dulany, Fruitland, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Myocardial Insufficiency</i> <i>Coronary Artery heart disease.</i> <i>Coronary artery disease</i>						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. Salisbury, Maryland		20f. (City or town) Salisbury	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from <u>March 24, 1957</u> to <u>March 24, 1957</u> that I last saw the deceased alive on <u>March 24, 1957</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>David F. Gilmore</u>						ADDRESS (Street, city or town, state) M.D. Salisbury, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/57		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery		22d. LOCATION (City, town, or county) Fruitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-25-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway		

BUREAU V.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03437

CERTIFICATE OF DEATH

03447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 2 yrs 10 mo. 14		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. Cambridge, Maryland		d. STREET ADDRESS 819 Roselin Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Henry	Last Dunn	4. DATE OF DEATH March	Month 10	Day 19	Year 57
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1869	9. AGE (in years lost birthday) 88	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Dunn				14. MOTHER'S MAIDEN NAME Mary Louise Calloway				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records		Address Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 24, 1954, to Mar. 10, 1957, that I last saw the deceased alive on Mar. 10, 1957, and that death occurred at 6:45 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Salisbury, Maryland		
ACTUAL SIGNATURE Andres Grisolia PHYSICIAN'S NAME (Type)		DATE SIGNED 3/10/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 12, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem Park		22d. LOCATION (City, town, or county) Cambridge Md		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Services		ADDRESS Cambridge Md		24a. REC'D BY REGISTRAR DATE 3/10/57		24b. REGISTRAR'S SIGNATURE May 10 1957		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAR 2 1957

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03448

03479

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
3. NAME OF DECEASED (Type or print) Margaret		First Alice	Middle Evans
4. DATE OF DEATH Mar. 2nd		Month Month	Day Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-27-1969		9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Whitemville, Del		12. IF UNDER 24 HRS Days 0	13. IF UNDER 24 HRS Hours 0
14. MOTHER'S MAIDEN NAME Lovey Foskey		15. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		17. INFORMANT Leslie Evans, Delmar, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cardiac failure			
(c) DUE TO arteriosclerotic heart disease		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2 , 19 52 , to death , 19 57 , that I last saw the deceased alive on Mar 1 , 19 57 , and that death occurred at 2A M, from the causes and on the date stated above. ACTUAL SIGNATURE Ernest Larmore M.D.		ADDRESS (Street, city or town, state) Delmar, Del DATE, SIGNED 3/3/57	
PHYSICIAN'S NAME (Type) Ernest Larmore		22c. NAME OF CEMETERY OR CREMATORIAL Line	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 2-5-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Line		22d. LOCATION (City, town, or county) (State) Whitesville, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Young, Delmar, Del		24a. REC'D. BY REGISTRAR DATE 195	
		24b. REGISTRAR'S SIGNATURE d. J. Sedwick	

RECEIVED
MAY 5 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03433

CERTIFICATE OF DEATH

Reg. Dist. No.

113449
337

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle	Last Fetkenher	4. DATE OF DEATH MARCH 29 1957	Month MARCH	Day 29	Year 1957
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1904	9. AGE (in years month/ day) 52 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Boatworks		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fetkenher		14. MOTHER'S MAIDEN NAME Elsie Rederpoof					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Busch, Teller, Dela		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 199.1		DUE TO Carcinomatosis (abdominal)		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe anemia. Atherosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) Wicomico	(State) Md.
21. I certify that I attended the deceased from 3-27 , 1957, to 3-29 , 1957, that I last saw the deceased alive on 3-29-57 , 1957, and that death occurred at Salisbury , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED March 29, 1957							
ACTUAL SIGNATURE William Fetkenher		M.D.					
FATHER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF March 31, 1957	22c. NAME OF CEMETERY OR CREMATORIUM East New Market		22d. LOCATION (City, town, or county) East New Market, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth S. Holloway		ADDRESS E. New Market		24a. REC'D. BY REGISTRAR DATE Mar 3 1957	24b. REGISTRAR'S SIGNATURE Mary H. Holloway		

BUREAU V. S.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 To be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03439 CERTIFICATE OF DEATH

03450

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD		First	Middle	Last	4. DATE OF DEATH MARCH 15 th 1957	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1934	9. AGE (In years last birthday) 22 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Employee of Fuller Brush Co., R.D. # 1		11. BIRTHPLACE (State or foreign country) Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Richard G. Foxwell				14. MOTHER'S MAIDEN NAME Evelyn E. Tomlin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth V. Foxwell (Wife) R.D. # 3 Delmar Md. Mr. Richard G. Foxwell (Father) Camden Ave. Ext.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		DUE TO		Salisbury, Maryland Diabetic Acidosis & Coma		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. b		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fruitland		(County) Maryland	(State) MD
21. I certify that I attended the deceased from 3-15-57 to 3-15-57 19 that I last saw the deceased alive on 3-15-57 19, and that death occurred at 11:00 AM , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Fruitland, Maryland	DATE SIGNED Mar. 17, 1957
ACTUAL SIGNATURE Lee Lawry									
PHYSICIAN'S NAME (Type) Dr. Lee Lawry				M.D.		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR MAK 2 15		24b. REGISTRAR'S SIGNATURE May 2 Holloway			

BUREAU V.

RECEIVED
MAR 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03451

03440

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>DORCHESTER</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>		d. STREET ADDRESS <i></i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Sarah</i>	Middle <i>Ida</i>	Last <i>Hembill</i>	4. DATE OF DEATH <i>MARCH 17 1957</i>	Month <i>MARCH</i>	Day <i>17</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED <input checked="" type="checkbox"/></i>	B. DATE OF BIRTH <i>JULY 20, 1867</i>	8. AGE (In years lost birthday) <i>94 yrs.</i>	9. IF UNDER 1 YEAR Months <i></i>	10. IF UNDER 24 HRS. Days <i></i>	11. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>CAROLINE CO. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>PERRY D. TAYLOR</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH (MAIDEN NAME UNKNOWN)</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>MRS. CARL L. PUSEY, SALISBURY, MD.</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute renal failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Fallen - Suspected Carcinoma of Breast</i>					
(c) <i>(Left side of Breast (carcinoma is obscured))</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senile at</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not-white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>3-10, 1957</i> to <i>3-17, 1957</i> , that I last saw the deceased alive on <i>3-17, 1957</i> , and that death occurred at <i>4:25 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i>3-23-57</i>	
ACTUAL SIGNATURE <i>Hunter R. Mann Jr.</i>	PHYSICIAN'S NAME (Type) <i>M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>MARCH 19, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>WASHINGTON CEMETERY</i>	22d. LOCATION (City, town, or county) <i>HURLOCK, MARYLAND</i>			(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. FRAMPTON AND SON, FEDERALSBURG, MD.</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>3-23-57</i>	24b. REGISTRAR'S SIGNATURE <i>Maryell Halloran</i>			

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be submitted within 24 hours after death.
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MAR 3 1957

PUREAU V. G.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03450

03452

Reg. Dist. No.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b In Village	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Village		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
3. NAME OF DECEASED (Type or print) ALICE		First MIDDLE VIRGINIA	Last GORDY
4. DATE OF DEATH MARCH 12th 1957		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1917
9. AGE (In years last birthday) 38 39rs.		10. IF UNDER 1 YEAR Months 8 Days 29 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Seaford Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John C. Bozman		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Ralph E. Gordy (Husband) Pittsville, Maryland Address	
17. INFORMANT Cerebral hemorrhage		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. Earl L. Royer		DATE SIGNED March 14 1957	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Pittsville Cemetery
22d. LOCATION (City, town, or county) Pittsville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR P. 1515 1957	24b. REGISTRAR'S SIGNATURE Mary W. Holloway

RECEIVED
BUREAU V. A.

MAR 15 1957

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03453

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wetover	
3. NAME OF DECEASED (Type or print) John		d. STREET ADDRESS	
4. DATE OF DEATH 3-22-57		5. FIRST NAME Gordy	MIDDLE NAME
6. SEX M	7. COLOR OR RACE C	8. DATE OF BIRTH	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Gordy		14. MOTHER'S MAIDEN NAME Lira Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 916.0		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Second and third degree burns of face and hands DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Sudden.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Decedent was paralyzed and trapped in house when stove exploded	
20c. TIME OF INJURY Hour o. m. 8:05 A.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Home
20f. (City or town) Wetover		(County) Wicomico	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/24/56		22c. NAME OF CEMETERY OR CREMATORIAL St Paul	
22d. LOCATION (City, town, or county) Reverend Neck, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr. Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE 3/26/57	
		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

RECEIVED
BUREAU V. S.

MAR 98 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

CERTIFICATE OF DEATH

Reg. Dist. No.

034534

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 206 Marshall St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAE		First DENNIS		Middle HANCOCK		4. DATE OF DEATH MARCH 22nd 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1886		9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 1	12. Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY (Operator)		11. BIRTHPLACE (State or foreign country) Near Whiton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Phillip Dennis		14. MOTHER'S MAIDEN NAME Annie Haddock							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Calvin J. Hancock (Son) 904 Spring Ave. Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 a d d s DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		b. DUE TO c.		Pulmonary edema degenerative heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County)	(State)			
21. I certify that I attended the deceased from <u>11/57</u> , 19 <u>57</u> , to <u>3/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>57</u> , and that death occurred at <u>9:57</u> A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE Dr. Earl H. Beardsley		M.D.		Salisbury, Md 3/22/57					
PHYSICIAN'S NAME (Type)				Maryland Ave. Salisbury, Maryland		March 22, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 25, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Church Cemetery	22d. LOCATION (City, town, or county) Walston, Maryland	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD		ADDRESS		24a. RECD BY REGISTRAR MAR 27 1957	24b. REGISTRAR'S SIGNATURE Mary J. Holloway				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03455

03443

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY		Wicomico, MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	a. STATE	Maryland
Salisbury		3 yrs. 10 mo.	b. COUNTY	Carroll
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Deer's Head State Hospital		None		

3. NAME OF DECEASED (Type or print)	First Maurice	Middle McKinney	Last Hawk	4. DATE OF DEATH	Month March	Day 11	Year 1957
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5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
Male	White	WIDOWED <input checked="" type="checkbox"/>	Nov. 5, 1877					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	--	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nelson Hawk	Mary Catherine Harner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Unk.	--	Deer's Head Hospital, Salisbury, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>	2 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	?	
(b) <i>Arteriosclerotic cardiovascular</i> DUE TO <i>disease</i>		
(c)		
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>April 13, 1953</u> , to <u>March 11, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	<i>Andres Grisolia</i> M.D. Deer's Head State Hospital Salisbury, Maryland	3/11/57
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery	22d. LOCATION (City, town, or county) Taneytown, Carroll, Maryland	(State)
Burial	March 13, 1957			
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D. BY REGISTRAR N.W.R. 13 1957	24b. REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>	
<i>Merwyn C. Fuss</i>	Taneytown, Maryland			

BUKEAU V. S.

MAR 12 1957

WILDFIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03456

03451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN lb 78 yrs						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 East Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar						
3. NAME OF DECEASED (Type or print) Joseph		First William	Middle Hearn					
4. DATE OF DEATH Mar. 9th	Month Year 1957	5. SEX Male	6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1878						
WIDOWED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) 78 yrs						
DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Employee, Post Office						
11. BIRTHPLACE (State or foreign country) Delmar, Del.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME George Martin Hearn		14. MOTHER'S MAIDEN NAME Theodosia LeCates						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-10-5706						
17. INFORMANT J. Elton Hearn, Delmar, Md.		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42c. <i>Arteriosclerotic</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis with Arteria stroke</i> 2 yrs DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <i>two hours</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Delmar	(County)	(State)
21. I certify that I attended the deceased from <i>Dec. 24, 1952, to Feb. 9, 1957</i> , that I last saw the deceased alive on <i>Feb. 8, 1957</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. L. Hearn</i>				ADDRESS (Street, city or town, state) <i>Delmar, Del.</i>				DATE SIGNED <i>"</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive		22d. LOCATION (City, town, or county) Delmar, Delaware		
22e. FUNERAL DIRECTOR'S SIGNATURE <i>W. S. Spano Co - Delmar, Del.</i>		ADDRESS <i>W. S. Spano Co - Delmar, Del.</i>		24a. REC'D BY REGISTRAR DATE MAR 14 '57		24b. REGISTRAR'S SIGNATURE <i>W. S. Spano Co - Delmar, Del.</i>		

BUREAU A.

MAR 34 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03457

034441

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY WICOMICO			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY			c. LENGTH OF STAY IN lb Peninsula General Hospital		
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION Peninsula General Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poquoson, Va.		
3. NAME OF DECEASED (Type or print) EULALIA			First Hickman	Middle 	Last
4. DATE OF DEATH MARCH 11 1957			Month MARCH	Day 11	Year 1957
5. SEX FEMALE			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Acornick		
11. BIRTHPLACE (State or foreign country) Acornick			12. CITIZEN OF WHAT COUNTRY? Acornick		
13. FATHER'S NAME John William Melvin			14. MOTHER'S MAIDEN NAME Margaret Ann Gray		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No			16. SOCIAL SECURITY NO. 		
17. INFORMANT 			Address 		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) DUE TO DUE TO DUE TO					
19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Acornick		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 3	Day 9	Year 1957	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) Acornick (County) Acornick (State) Acornick
21. I certify that I attended the deceased from 3-9 , 19 57 , to 3/11 , 19 57 , that I last saw the deceased alive on 3/11 , 19 57 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Acornick, Va.					
DATE SIGNED Acornick, Va.					
ACTUAL SIGNATURE Wilbur Q. Ellis, Jr.		M.D. Wilbur Q. Ellis, Jr.			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/57		22c. NAME OF CEMETERY OR CREMATORIAL Edgewater	
22d. LOCATION (City, town, or county) Acornick				(State) Acornick	
23. FUNERAL DIRECTOR'S SIGNATURE Hugh W. Lewis, Jr.		ADDRESS Acornick, Va.		24a. REC'D'D BY REGISTRAR DATE MAR 18 1957	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log 4 may be retained by the hospital or attending physician.

VS A1S (4)
15M 9/SS

FRANCY V. S

1957

11 E. 20th ST.

HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03445

CERTIFICATE OF DEATH

03458

337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Worcester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>7 Clarke Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Lula M. Hitchens</i>		First	Middle
4. DATE OF DEATH Month <i>3</i>		Month	Day
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MARCH 23 1893</i>		9. AGE (in years last birthday) <i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
10c. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>THOMAS A. GERMAN</i>		14. MOTHER'S MAIDEN NAME <i>OLIVIA BAKER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-22-4687</i>	
17. INFORMANT <i>FORD D. HITCHENS, JR., POCOMOKE, MD.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>		INTERVAL BETWEEN DEATH AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Hallwood, Virginia</i>
21. I certify that I attended the deceased from <i>3-4</i> , 19 <i>57</i> , to <i>3-13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3-13</i> , 19 <i>57</i> , and that death occurred at <i>9:15 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>William R. Eddies, Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>3-13-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-15-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>GROTON CEMETERY</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry St. Watson</i>		24a. REG'D. BY REGISTRAR DATE <i>MAR 18 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>

testes & ova of *Leucaspis* were found in the *Leucaspis* infested *Acacia* leaves.

وَجَاهَهُمْ أَنَّهُمْ لَمْ يَرْجِعُوا إِلَيْهِمْ مَمْوَالَهُمْ

1865

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103459

03446

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b All his life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Spring Hill Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Jrione	Middle Z	Last Holland	4 DATE OF DEATH	Month 3	Day 14	Year 1957
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/16/1905	9 AGE (In years less birthday) 51 yrs	10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing Co.		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Holland				14. MOTHER'S MAIDEN NAME Annie Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. 214 12 6812		17. INFORMANT Mrs. Susan Hyman, Sp Hill Rd, Salisbury, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 year?							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lung abscess							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19, 1957, to March 14, 1957, that I last saw the deceased alive on March 14, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Physician's Name (Type) D. L. Schler M.D. 303 East Street, Delmar 316-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/57		22c. NAME OF CEMETERY OR CREMATORIAL Green Acre Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Mary J. Holloway

BUREAU V. S

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03460

03432

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Mardela Rural						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1 (Athol Road)				d. STREET ADDRESS R.D. # 1 (Athol Road)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) (ALEX) ALEXANDER		First	Middle	Last	HOPKINS	4. DATE OF DEATH	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 29, 1867		9. AGE (In years at birthday) 89	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 5	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware USA		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Joshua James Hopkins				14. MOTHER'S MAIDEN NAME Sarah Mills						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James W. Hopkins (Son) R.D. # 1 (Athol Road) Mardela, Maryland		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. (b) <u>Arteriosclerosis</u> (c) <u></u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M. D. Main St.	(County)	(State)		
21. I certify that I attended the deceased from <u>March 1, 1957</u> to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 3, 1957</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William Enrich</u> ADDRESS (Street, city or town, state) <u>Hebron, Maryland</u> DATE SIGNED <u>March 4, 1957</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Emmanuel Church Cemetery		22d. LOCATION (City, town, or county) Mardela, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		ADDRESS Holloway & Company Funeral Home — Salisbury, MD.		24a. REC'D BY REGISTRAR DATE 3/7/1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway				

HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEAU V. 8

197 1987

EL CANTERO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03447

CERTIFICATE OF DEATH

03461

332

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it is completely filled in. It should be filed with page 3 should be filed for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Salisbury		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Carey Ave. R.D. # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE		Middle ELLEN		Last HUMPHREYS		4. DATE OF DEATH MARCH 14th 1957	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1903		9. AGE (in years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 23		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work - Shirt Factory Employee		10b. KIND OF BUSINESS OR INDUSTRY House Work - Shirt Factory Employee		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Thomas Hastings		14. MOTHER'S MAIDEN NAME Mabel Jenkins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 214-10-6482		17. INFORMANT Mrs. Harry Austin (Daughter) R.D. #3 Carey Ave. Salisbury, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		ACUTE PULMONARY EDEMA				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1.70.0		DUE TO MASSIVE LUNG CANCER							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO (c)		DISSEMINATED CERVICAL CANCER							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Nat while of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/18/56, 19, to 3/14, 1957 that I last saw the deceased alive on 12, and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. Maryland Ave. (Office) Mar. 15 1957									
ACTUAL SIGNATURE Dr. Andrew C. Mitchell PHYSICIAN'S NAME (Type) Dr. O.J. Burton		Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD		ADDRESS		24a. REC'D BY REGISTRAR DATE 13 1057		24b. REGISTRAR'S SIGNATURE Mary J. Holloway			

BUNAU V. S

MR 10 1970

EX-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03448

03462

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>		b. COUNTY <i>Sussex</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delmar</i>		d. STREET ADDRESS <i>200 Shore</i>															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Clemson Hospital</i>		First <i>William</i> Middle <i>Jackson</i> Last <i>Jackson</i>		4. DATE OF DEATH <i>3-12-1957</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <i>William Jackson</i>		5. SEX <i>Male</i> COLOR OR RACE <i>White</i>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH <i>9-11-1902</i>		8. AGE (In years last birthday) <i>54 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		10. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electric Co</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Klaran</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>189-05-6193</i>		17. INFORMANT <i>Josephine Jackson</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>222 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cerebral Hemorrhage</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f (City or town) Salisbury</i>		(County) <i>Wicomico</i>		(State) <i>Maryland</i>		21. I certify that I attended the deceased from <i>March 3, 1957</i> to <i>March 12, 1957</i> that I last saw the deceased alive on <i>March 12, 1957</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Josephine Jackson</i>		22. ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		23. DATE SIGNED <i>March 12, 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-15-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olive</i>		22d. LOCATION (City, town, or county) <i>Delmar</i>		24a. REC'D BY REGISTRAR MAY 11 1957		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>											
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Jackson</i>		ADDRESS																			

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03463

03449

CERTIFICATE OF DEATH

Reg. Dist. No. 337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exercised within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wyoming		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware		b. COUNTY Sussex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS R. R #1.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Phillip		First	Middle	Last	4. DATE OF DEATH JAMES	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/11/1884		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Reuben Jones		14. MOTHER'S MAIDEN NAME Annie Short						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Fannie Short, Surfside, Del.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199x		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Bacillary pneumonia Cerebral & liver & coronary trouble		INTERVAL BETWEEN ONSET AND DEATH 3 months		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel Hill Con.		20f. (City or town) Laurel		(County) (State)
21. I certify that I attended the deceased from 1-6, 1957, to 3-8, 1957, that I last saw the deceased alive on 3-8, 1957, and that death occurred at 10:40 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE William H. Short				ADDRESS (Street, city or town, state) Laurel, Delaware		DATE SIGNED 3-11-57		
PHYSICIAN'S NAME (Type) William H. Short								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/57		22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Con.		22d. LOCATION (City, town, or county) Laurel, Delaware		(State)
23. FUNERAL DIRECTOR'S SIGNATURE John H. Holloman		ADDRESS Laurel, Delaware		24a. RECD. BY REGISTRAR DATE MAR 11 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloman		

BUREAU V. 1

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03464

03450

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		d. STREET ADDRESS 732 JACKSON STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS 732 JACKSON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM Thomas		First	Middle	Last	4. DATE OF DEATH JAMES IV	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1957	9. AGE (in years lost birthday) yrs. 2	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Days 8	Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. James III				14. MOTHER'S MAIDEN NAME Jancis Costen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Wm. T. James III, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7. <i>Neumonitis, acute.</i>						INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
Secondary DUE TO Conditions, if any, which gave rise to immediate cause (b) Severe dehydration + acidosis 48 hrs									
Tertiary DUE TO Conditions, if any, which gave rise to immediate cause (c) Hydrocephalus, congenital.						9 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Neuromyelitis with paraparesis of lower ext.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) ---	(State) ---
21. I certify that I attended the deceased from Mar 14, 1957 to Mar 15, 1957 that I last saw the deceased alive on Mar 15, 1957 , and that death occurred at 10.00 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 926 N. Division St., Salisbury, Md.		DATE SIGNED 3/15/57	
ACTUAL SIGNATURE R. W. Saunderson, Jr.									
PHYSICIAN'S NAME (Type) R. W. Saunderson, Jr.									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/57		22c. NAME OF CEMETERY OR CREMATORIAL Grace Epic. Chruchyard		22d. LOCATION (City, town, or county) Mt. Vernon, Maryland		(State) ---	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co., Salisbury, Maryland		ADDRESS ---		24a. REC'D BY REGISTRAR 3/18/57		24b. REGISTRAR'S SIGNATURE Maryell Holloway			
VS A15 (4) 1SM 9/55									

BUREAU V. S.

JAN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0346537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro.		d. STREET ADDRESS Springhill Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs. Nannie E. Jarrell		First	Middle	Last	4. DATE OF DEATH 3-4-57	Month	Day	Year 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1866	9. AGE (In years last birthday) 90 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Caroline Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Hugh Duffey		14. MOTHER'S MAIDEN NAME Catherine See						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Joseph M. Eaton, Hillsboro		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4425 DUE TO <i>Cardiovascular renal disease</i>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerosis</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hillsboro		(County) Caroline (State) Md.
21. I certify that I attended the deceased from 5-3-53 to 5-4-53 , that I last saw the deceased alive on 5-3-53 , and that death occurred at 5:15 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Hillsboro, Md.		DATE SIGNED 3/4/57
ACTUAL SIGNATURE <i>Philip A. Tinsley</i>		M.D.						
PHYSICIAN'S NAME (Type) Philip A. Tinsley								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/6/57		22c. NAME OF CEMETERY OR CREMATORIAL Greenmount		22d. LOCATION (City, town, or county) Hillsboro, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip A. Tinsley</i>		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 3/7/57		24b. REGISTRAR'S SIGNATURE Mary H. Hollings		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BEREAU V.

MAR 7 1957

BEREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03452

CERTIFICATE OF DEATH

03466
337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Salisbury		c. LENGTH OF STAY IN 1b 7 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - POCOMOKE CITY		d. STREET ADDRESS BOX 81	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS BOX 81		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First F.	Middle .	Last Justice	4. DATE OF DEATH March	Month 9	Day Year 1957
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 14, 1889	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE STATION ATTENDANT		11. KIND OF BUSINESS OR INDUSTRY ---		12. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME WILLIAM H. JUSTICE		14. MOTHER'S MOTHER'S NAME GALLIE DIX		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-26-8450 17. INFORMANT MRS ANNIE E. JONES, STOCKTON, MARYLAND Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Carcinoma of lung						INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1957, to March 9, 1957, that I last saw the deceased alive on March 9, 1957, and that death occurred at 4:03 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE WILLIAM H. ELLIS, Jr.		M.D.					
PHYSICIAN'S NAME (Type)							

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-12-57	22c. NAME OF CEMETERY OR CREMATORIUM BRITTINGHAM CEMETERY	22d. LOCATION (City, town, or county) RURAL POCOMOKE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson		ADDRESS POCOMOKE, MD.	24a. REGD BY REGISTRAR MAR 15 1957
			24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be held for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 13 1957

SEARCHED
INDEXED
SERIALIZED
FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03453

03467
33v

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 214 West Locust St	
3. NAME OF DECEASED (Type or print) (BABY) First STARR Middle LYNN Last LARMORE		4. DATE OF DEATH Month MAR. Day 18th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 18, 1957
9. AGE (in years (at birthday) 0 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 1 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Max Larmore		14. MOTHER'S MAIDEN NAME Beatrice Meredith Budd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Raymond Max Larmore (Father) Address Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure; congenital microcephaly, cyclopia</i> DUE TO <i>congenital</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>deformity and absence of nose</i> DUE TO <i></i> (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 57, to <u>Mar. 18th, 19 57</u> , that I last saw the deceased alive on <u>Mar. 18th, 19 57</u> , and that death occurred at <u>2:30A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Delmar, Delaware</u> DATE SIGNED <u>March 18, 1957</u>			
ACTUAL SIGNATURE <u>Ernest M. Larmore</u>		PHYSICIAN'S NAME (Type) Dr. E. M. Larmore	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Meth Cemetery		22d. LOCATION (City, town, or county) Bivalve, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD		24a. REC'D BY REGISTRAR DATE <u>Mar. 21 1957</u>	
		24b. REGISTRAR'S SIGNATURE DATE <u>Mary H. Holloway</u>	

RECEIVED
BUREAU V.

MAR 21 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03468

332

03483

CERTIFICATE OF DEATH

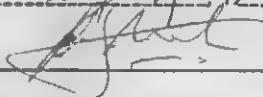
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Eden Rt 2		c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Eden Rt 2			
3. NAME OF DECEASED (Type or print) Helen May Leatherbury		4. DATE OF DEATH 3	Month Day Year 8 1957		
5. SEX F.F.	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1905		
9. AGE (In years from last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Stephen Jones		14. MOTHER'S MAIDEN NAME Bertha Tull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No *****		16. SOCIAL SECURITY NO. William Leatherbury, Eden, Md. Rt 2			
17. INFORMANT William Leatherbury, Eden, Md. Rt 2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from 1 Feb 1956, to 8 March 1957, that I last saw the deceased alive on 8 March 1957, and that death occurred at 8 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 622 W. Main St., Salisbury, Md. 8 March 57 DATE SIGNED					
ACTUAL SIGNATURE <i>E. A. Purnell</i>					
PHYSICIAN'S NAME (Type) E. A. Purnell, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/1957		22c. NAME OF CEMETERY OR CREMATORIAL Church Cemetery	
22d. LOCATION (City, town, or county) " (State)				22e. REG'D BY REGISTRAR Polks Road, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		ADDRESS		24b. REGISTRAR'S SIGNATURE MAY 14 1957 <i>Mary H. Holloway</i>	
24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE	

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MAR 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03469	Reg. Dist. No. 332		
03454 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Wicomico								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12. Salisbury								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 W. Vine St					d. STREET ADDRESS 104 W. Vine St					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	LAST	4. DATE OF DEATH		Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1871	9. AGE (In years lost birthday) 85 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME Benjamin Peter Livingston					14. MOTHER'S MAIDEN NAME Martha Carey								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mr. William H. Livingston (Son) 202 Holland Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS										INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
DUE TO (b) ATHEROSCLEROS + HYPERTENSION										Years.			
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONGESTIVE CARDIAC FAILURE.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Nov. 7, 1953, to 11, 1957, that I last saw the deceased alive on 2/28/1957, and that death occurred at 5:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) Dr. O.J. Burton M.D. Maryland Ave. Mar. 1 1957										ADDRESS (Street, city or town, state)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.					24a. REC'D BY REGISTRAR DATE MAR 4 1957					24b. REGISTRAR'S SIGNATURE MAY 3 Holloway			

BUREAU V. 3

MAP 4 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03455

CERTIFICATE OF DEATH

03470

337

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY TOWN	Wicomico If outside corporate limits, write RURAL OR and give nearest town Salisbury	MARYLAND LENGTH OF STAY (in this place) Since 5/11/56	STATE CITY OR TOWN Maryland Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Pine Bluff State Hospital Salisbury, Maryland			
3. NAME OF DECEASED (Type or Print)	(First) Herbert	(Middle) Wilson	(Last) Lowe, Sr.	
4. DATE OF DEATH	Month March	Day 23	Year 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	
Male	White	Widowed	Nov. 7, 1876	
9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS	
80 yrs.	Months 4	Days 16	Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		
Farmer		Salisbury, Maryland		
12. CITIZEN OF WHAT COUNTRY?	USA			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
John Samuel Lowe	Ida Isabella Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS		
No	None	Patient when admitted to hospital		
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
002X IMMEDIATE CAUSE (A) Cardiac Failure				
ANTECEDENT CAUSE(S) DUE TO				
DISEASES OR CONDITIONS, IF ANY, (B) Pulmonary Tuberculosis				
GIVING RISE TO THE ABOVE CAUSE DUE TO				
STATING UNDERLYING CAUSE LAST. (C)				
INTERVAL BETWEEN ONSET AND DEATH Sudden 1 yr.				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 11, 1956, to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 6:40 A.M. from the causes and on the date stated above. SIGNATURE <i>St. Buder</i> ADDRESS (Street, city, town, state) DATE SIGNED 3/23/57				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CEMETORY LOCATION (City, town, or county) (State) Burial March 26-57 Wicomico Mem. Park Salisbury Md.				
24. RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1955 Mary H. Holloway 1955 <i>St. Buder, Salisbury Md.</i>				
DATE				

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BUREAU X.

MAR 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03471

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wisomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardele Springs		b. COUNTY Wisomico	
c. LENGTH OF STAY IN 1b 3 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sharptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Maple Shade Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Edward	Last Lowe
4. DATE OF DEATH	Month March	Day 22	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1870
			9. AGE (in years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Fish	
11. BIRTHPLACE (State or foreign country) Dorchester County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Lowe		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT L. Fulton Lowe, Sharptown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 215X Condition(s) if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 day ?	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 20</u> , 1957, to <u>Mar 22</u> , 1957, that I last saw the deceased alive on <u>Mar 22</u> , 1957, and that death occurred at <u>8159</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE H. J. Kehlman	M.D.	DATE SIGNED 3/23/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-24-1957	22c. NAME OF CEMETERY OR CREMATORIUM East New Market	22d. LOCATION (City, town, or county) (State) East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenda W. Hamm - Sharptown, Md.		24a. REC'D BY REGISTRAR DATE MAR 23 1957	
		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

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BUREAU V. S

1937

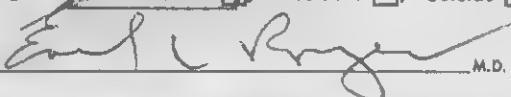
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337

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury life		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 608 Pearl St.		d. STREET ADDRESS 608 Pearl St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irwin		First	Middle
4. DATE OF DEATH 3 29 1957		Last	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY child	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irwin Mitchell		14. MOTHER'S MAIDEN NAME Clara Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. C	17. INFORMANT Irwin Mitchell Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Froncho-pneumonia	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 14-5-57	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-57	22c. NAME OF CEMETERY OR CREMATORIAL Berens Cem
22d. LOCATION (City, town, or county) Freeland and		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE People's Mortuaries 782184 XVC		ADDRESS	24a. REC'D BY REGISTRAR DATE 4/10/57
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. S.

APR 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472

03456

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS 231 Middle Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLYDE	Middle ORRIS	Last NOCK
4. DATE OF DEATH	Month MARCH	Day 18th	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1888
9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative (Employee of Drug Co.)	10b. KIND OF BUSINESS OR INDUSTRY Accomac County, Virginia	11. BIRTHPLACE (State or foreign country) Accomac County, Virginia	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Samuel W. Nock	14. MOTHER'S MAIDEN NAME Sudie B. Colona		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Lelia J. Nock (Wife) 231 Middle Blvd. Salisbury, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days Coronary thrombosis Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Philip A. Insley PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 21, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	22d. LOCATION (City, town, or county) Salisbury, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE D 20 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03457

331

03457

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Glenmore	Middle H.	Last Parker	4. DATE OF DEATH	Month 3	Day 12	Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1898	9. AGE (In years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Parsonsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME John W. Parker		14. MOTHER'S MAIDEN NAME Annie Mitchell		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tell, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-3945		17. INFORMANT Maxine Fisher		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. INTERVAL BETWEEN ONSET AND DEATH Weeks		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parsonsburg, Md.	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from 8/1/2 , 1957, to 3/12 , 1957, that I last saw the deceased alive on 8/1/2 , 1957, and that death occurred at 6 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Earl M. Beardsley		ADDRESS (Street, city or town, state) Parsonsburg, Md.		DATE SIGNED 3/12/57				
22a. BURIAL, CREMATION, REMOVAL* (Specify) Burial		22b. DATE THEREOF 3/17/57		22c. NAME OF CEMETERY OR CEMINATORY Glass Hill		22d. LOCATION (City, town, or county) Parsonsburg, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Enton F. Stewart		ADDRESS Salis. Md.		24a. REC'D. BY REGISTRAR DATE 3/17/57		24b. REGISTRAR'S SIGNATURE Mary H. Holloway				

BUREAU Y.

MAR 20 1957

REGELIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 File No. 25783
CERTIFICATE OF DEATH

03458 337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital			d. STREET ADDRESS R.D. # 1					
3. NAME OF DECEASED (Type or print) LOUISE			4. DATE OF DEATH MAR. 18th 1957	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1922	9. AGE (In years last birthday) 34 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 7	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Allen Hooper			14. MOTHER'S MAIDEN NAME Ruby Truitt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Daniel Parkinson (Husband)	Address Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			Acute Dilatation (Acute Cardiac Dilatation) due to Bronchial Asthma and Status Asthmaticus Due to Bronchial Asthma & Status Asthmaticus.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nasal and Sinus Polyposis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. f. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County)	(State)	
21. I certify that I attended the deceased from 9/31/53 to 3/18/57 , that I last saw the deceased alive on 3/18/57 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Mar. 19, 1957								
ACTUAL SIGNATURE 			PHYSICIAN'S NAME (Type) Dr. Zack J. Waters					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 20, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	22d. LOCATION (City, town, or county) Salisbury	22e. (State) Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			24a. ADDRESS 2313-17	24b. REGISTRAR'S SIGNATURE Mary J. Holloway				

BUREAU V. A.
RECEIVED

MAR 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03475

332

03485

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware		b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Rural		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville Delaware		d. STREET ADDRESS 4 A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David		First	Middle	Last	4. DATE OF DEATH March 19	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1876	9. AGE (In years less birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Amos Petry				14. MOTHER'S MAIDEN NAME Sarah Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X		17. INFORMANT Mrs. Lucele P. Leone		Address Washington D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Myocardial Insufficiency</i> DUE TO <i>Arteriosclerotic Heart Disease</i> (c) <i>2 months</i> DUE TO									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. y., p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Selbyville	(County) Del.	(State) Del.
21. I certify that I attended the deceased from <i>Mar. 8, 1957</i> , to <i>March 18, 1957</i> , that I last saw the deceased alive on <i>March 18, 1957</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Salisbury Md</i>									
DATE SIGNED <i>March 20, 1957</i>									
ACTUAL SIGNATURE <i>David J. Silmore M.D.</i>									
PHYSICIAN'S NAME (Type) <i>Red Men</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Red Men		22d. LOCATION (City, town, or county) Selbyville			
(State) Del.									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Peter Whaley Selbyville Del.</i>									
24a. REC'D BY REGISTRAR MAR 22 1957									
24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>									

BUREAU V.

APR 23 1957

U.S. GOVERNMENT PRINTING OFFICE: 1957 7-1200-1

03476

03459

CERTIFICATE OF DEATH

Reg. Dist. No

DO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia		b. COUNTY Accomack		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give, nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague		d. STREET ADDRESS 165 Smith Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas James Pitts		First Thomas	Middle James	Last Pitts	4. DATE OF DEATH March 17 1957	Month March	Day 17	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873		9. AGE (In years, months and days) 84 yrs.	10. IF UNDER 1 YEAR Months 82		11. IF UNDER 24 HRS. Days 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Waterman		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) GREEN RUN MD		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James R. Pitts		14. MOTHER'S MAIDEN NAME Mary A. Birock		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		
17. INFORMANT Henry Pitts, Chincoteague U.S.A.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 2 days		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chincoteague	20f. (City or town) Salisbury	(County) Wicomico	(State) MD
21. I certify that I attended the deceased from March 16, 1957 , to March 17, 1957 , that I last saw the deceased alive on March 17, 1957 , and that death occurred at 6:03 P.M. from the causes and on the date stated above.		22. ACTUAL SIGNATURE David J. Gilmore		23. PHYSICIAN'S NAME (Type) David J. Gilmore		24. ADDRESS (Street, city or town state) Salisbury, Md.		DATE SIGNED March 22, 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 20, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Mechanics		22d. LOCATION (City, town, or county) Chincoteague Va		(State)
23. FUNERAL DIRECTOR'S SIGNATURE William B. Salter		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-22-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway		

RECEIVED
BUREAU V. S.

MAR 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03477

Reg. Dist. No.

337

03460

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office on 10th Street, Baltimore, MD 21202. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used on a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b /		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Hermon on Schumaker Rd						d. STREET ADDRESS / 115 E. College Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		First	Middle	Lost	4. DATE OF DEATH MARCH 22nd 1957	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1891	9. AGE (In years last birthday) 65 yrs.	10. UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Emory Price				14. MOTHER'S MAIDEN NAME Laura V. Wingate					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		INFORMANT Mrs. Bessie M. Price (Wife) ^{Address} 115 E. College Ave. Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH Studien.			
PART I. DEATH WAS CAUSED BY: 423-1 IMMEDIATE CAUSE (a) Died-3:00P.M.		Coronary occlusion							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Leceased collapsed in customers home.							
20c. TIME OF INJURY Hour 3 P		Month, Day, Year a. m. 3 22 1957	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Salisbury	(County) Wicomico	(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Earl L. Royer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 25 1957			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22c. BURIAL, CREMATION REMOVAL (Specify) Burial		22d. DATE THEREOF Mar. 25, 1957	22e. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	22f. LOCATION (City, town, or county) Salisbury, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR MAR 27 1957	24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>				

RECEIVED
BUREAU V. 2

MAR 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03461

CERTIFICATE OF DEATH

113478
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE							
NICOMICO MARYLAND		b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shaptown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First	Middle						
4. DATE OF DEATH		Month	Day						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
MALE COLORED									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
				Maryland		Shaptown, Maryland			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Wilson Quinton		Lula Mae Brown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes				Lula Mae Brown		Shaptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Acute pulmonary congestion		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		Congestive heart failure, right sided, acute 1 1/2 hrs					
(c)		DUE TO		Unknown etiology					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		acute tracheobronchitis, of newborn, diffuse congestion, glau.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County)		(State)	
21. I certify that I attended the deceased from 16 May 1957 to 1957, and that I last saw the deceased alive on 19 May 1957, and that death occurred at 10 A.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type)						3/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Cremation		3/18/57		Peninsula General Hospital		Salisbury		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Peninsula General Hospital				DATE 1957		Maryell Holloway			

1 HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log in
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

MAR 20 1957

RECEIVED

03479
332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03486
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
3. NAME OF DECEASED (Type or print) SADIE		Middle SIMMS	4. DATE OF DEATH RUARK 3 23 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 6, 1881
9. AGE (In years lost birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aulus Simms		14. MOTHER'S MAIDEN NAME Charlotte Whayland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-03-4704 17. INFORMANT Mrs. Mary Hearn	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Myocardial infarct coronary thrombosis	
DUE TO (b) DUE TO (c) coronary atherosclerosis			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 303 East Street, Delmar, Maryland, March 23, 1957	
ACTUAL SIGNATURE L. V. Sohler M.D.		PHYSICIAN'S NAME (Type) L. V. Sohler	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/1957 22c. NAME OF CEMETERY OR CREMATORIUM St. John's Church Cemetery	
22d. LOCATION (City, town, or county) Fruitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 3-25-57	
ADDRESS 7 moment Baker		24b. REGISTRAR'S SIGNATURE Maryill H. Hinesay	

BUREAU V.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03481

CERTIFICATE OF DEATH

Reg. Dist. No. 337

03487

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be delivered to the funeral director.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be delivered to the funeral director.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Wicomico Shad Point R.D. # 1 Salisbury	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET / ADDRESS R.D. # 1 Salisbury
3. NAME OF (First) (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH MARCH 29th 19 57	
MARY		SCHIEBEL	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 20, 1891
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME No Record		11. BIRTHPLACE (State or foreign country) Augsburg, Germany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mr. Louis Brewington (Friend) Shad Point R.D. # 1 Salisbury, Maryland		14. MOTHER'S MAIDEN NAME Theresa B. Palme	
18. MEDICAL CERTIFICATION <i>Generalized carcinoma of carcinoma of head of pancreas</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1. <i>Cancer</i> IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) _____ (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH 8-6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. While at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/4/1956</i> to <i>3/28/1957</i> , that I last saw the deceased alive on <i>3/27/1957</i> , and that death occurred at <i>3:00A.M.</i> from the causes and on the date stated above. SIGNATURE <i>William H. Fisher Jr.</i> ADDRESS (Street, city, town, state) Dr. William H. Fisher Jr. <i>Medical Center</i> Salisbury, Maryland Mar. 30/57 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		DATE THEREOF Mar. 31, 1957	
24. REC'D BY REGISTRAR DATE APR 2 1957		NAME OF CEMETERY OR CREMATORIUM Shad Point Cemetery	
REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		LOCATION (City, town, or county) R.D. # 1 Salisbury, Maryland (State)	
25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND		ADDRESS	

RECEIVED
1957
SULZAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03482

03462

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		b. COUNTY WORCESTER	
c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN 22X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS R.R.#3	
3. NAME OF DECEASED (Type or print) John		First P	Middle Short
4. DATE OF DEATH MARCH 15 1957	Month March	Day 15	Year 1957
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (State or foreign country) BERLIN MD
13. FATHER'S NAME Unknown		14. MOTHER'S M AIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. KATIE SHORT
			Address BERLIN MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hemorrhage { Internally externally			
(c) Gastric Bleeding.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-13 1957 to 3-15 1957 that I last saw the deceased alive on 3/14/57 1957, and that death occurred at 8:26 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Cassie D. Heaton PHYSICIAN'S NAME (Type) Cassie D. Heaton	3/14/57 1957 8:26 AM 226 N. Davis Street Salisbury, Md. 226 N. Harrison Street Salisbury, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/17/57	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BECOMBE (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Anne S. Burbage	ADDRESS Berlin MD	24a. REG'D BY REGISTRAR MAR 18 1957	24b. REGISTRAR'S SIGNATURE Margie Delaney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be filed for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENOS AIRES

Aug 13 1957

W.M.C. 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 03463
CERTIFICATE OF DEATH

11348332
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>6 HOURS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>		d. STREET ADDRESS <i>W. T. ALLEN Co.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>W. J.</i>	Middle <i>Judge</i>	Last <i>W.</i>	4. DATE OF DEATH <i>SKINNER.</i>	Month <i>MARCH</i>	Day <i>16</i>	Year <i>1957</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>about 7/10/1894</i>	9. AGE (In years from last birthday) <i>63</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BURNER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FRUIT Growers</i>		11. BIRTHPLACE (State or foreign country) <i>NORTH Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George L. Skinner</i>		14. MOTHER'S MAIDEN NAME <i>Anna Jones</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-05-9263</i>		17. INFORMANT <i>P. A. Skinner, 148-25 89 Ave, Jamaica, N. Y.</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		<i>Acute Appendicitis</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<i>Causing perforation</i>							
DUE TO (b)		<i>Intestinal obstruction</i>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March 1957</i> to <i>March 1957</i> , that I last saw the deceased alive on <i>March 1957</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. J. Skinner M.D.</i>		ADDRESS (Street, city or town, state) <i>226 N. Maryland St., Apt. 202, Salisbury, Maryland</i>						DATE SIGNED <i>2/26/18</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/19/1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Acre Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Salisbury, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart Funeral Home, Salisbury, Maryland</i>		ADDRESS <i>J. F. Stewart Funeral Home, Salisbury, Maryland</i>		24a. RECD BY REGISTRAR <i>MR</i>		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		DATE	

BUREAU V.

MAR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

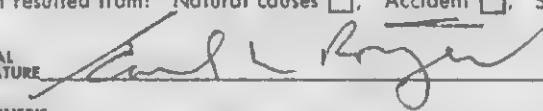
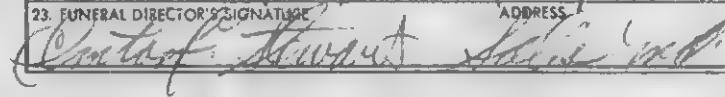
03464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03484
331

Reg. Dist. No.

1 **NOTIFY MEDICAL EXAMINER:** This certificate should be mailed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Halistine		First	Middle
4. DATE OF DEATH Smith		Month	Day
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9/2/55	9. AGE (in years last birthday) 11 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY child	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ervin Smith		14. MOTHER'S MAIDEN NAME Loretta Purnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Child Ervin Smith Berlin Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 881.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Child ingested 2 or more tablespoonsful of Kerosene.		Address 2 hours 3 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child ingested two or more tablespoonsful of kerosene.			
20c. TIME OF INJURY Hour 11:30 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Berlin		(County) (State) Worcester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED 3-24-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/57	
22c. NAME OF CEMETERY OR CREMATORIAL Quepunca		22d. LOCATION (City, town, or county) Berlin	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. REC'D BY REGISTAR DATE MAR 27 1957	
		24b. REGISTRAR'S SIGNATURE 	

BUREAU Y.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03488

CERTIFICATE OF DEATH

03485

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		c. LENGTH OF STAY IN 1b 1b		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allen		d. STREET ADDRESS In Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last TAYLOR		4. DATE OF DEATH Month March Day 3rd Year 1957							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 6, 1872	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jane Taylor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 22		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Thomas E. Taylor (Son) 807 E. William St. S. Salisbury, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Main St.		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1st, 1957</u> to <u>March 2nd, 1957</u> that I last saw the deceased alive on <u>March 1st, 1957</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William Enrich</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Dr. William Enrich M.D. Main St. (Office) DATE SIGNED March 4 1957									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1957		22c. NAME OF CEMETERY OR CREMATORIY Allen Cemetery		22d. LOCATION (City, town, or county) Allen, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLYDAY & COMPANY FUNERAL HOME -- SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR MAR 7 1957		24b. REGISTRAR'S SIGNATURE Mary J. Holloway			

DAU V. 2

BR 7 1957

MECHNIK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03465

CERTIFICATE OF DEATH

03486
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Spring Hill Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Road				d. STREET ADDRESS Spring Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH Month 3	Day 21	Year 1957
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 86		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME Henry Thomas		14. MOTHER'S MAIDEN NAME Lillian Harmon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Cathrine A. Thomas		Address Spring Hill Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hypertension		Hyperensive Cardiovascular Disease. Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 21 Mar 1957 , and that death occurred at 1 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 617 W Main, Salisbury, Md.					
ACTUAL SIGNATURE E.A. PURNELL		DATE SIGNED 22 Mar 57					
PHYSICIAN'S NAME (Type) E.A. PURNELL							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/24/57		22c. NAME OF CEMETERY OR CREMATORIAL Green Acres		22d. LOCATION (City, town, or county) (State) Salisbury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Center J. Stewart		ADDRESS Salisbury, Md.					
		24e. RECD BY REGISTRAR DATE MAR 26 1957					
		24f. REGISTRAR'S SIGNATURE Mary H. Holloway					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFUGEE

MAR 2 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03487

03466

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Per. Gen. Hospital		d. STREET ADDRESS R.D. # 3 (Mt Hermon)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle WILSON	Last TILGHMAN	4. DATE OF DEATH	Month March	Day 2nd	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 20, 1895	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 13	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill Operator		10b. KIND OF BUSINESS OR INDUSTRY Lumberman		11. BIRTHPLACE (State or foreign country) R.D. # 3 Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Daniel S. Tilghman				14. MOTHER'S MAIDEN NAME Ida Humphreys			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 314-12-6067		17. INFORMANT Mrs. Virzie T. Tilghman (wife) R.D. # 3 (Mt Hermon) Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1957</u> to <u>March 2, 1957</u> , that I last saw the deceased alive on <u>March 2, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED March 5 1957					
ACTUAL SIGNATURE <u>Dr. David J. Gilmore</u>		M.D. Medical Center					
PHYSICIAN'S NAME (Type)		Salisbury, Maryland					
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF Mar. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Memorial Gardens		22d. LOCATION (City, town, or county) R.D. # Hebron, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & CO. FUNERAL HOME — SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE DATE	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LAU V. 8

MAR 7 1957

KELLOGG COMPANY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03467

CERTIFICATE OF DEATH

03488

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS # 41 Belmont Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAVID	Middle GARLAND	Last TINGLE
4. DATE OF DEATH	Month MARCH	Day 12 th	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1892
9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 12	12. IF UNDER 24 HRS Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Operator (Restaurant)		11. BIRTHPLACE (State or foreign country) R.D. # Delmar Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME David Tingle		14. MOTHER'S MAIDEN NAME Martha Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. William F. Tingle (Son) #41 Belmont Ave. Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any.		INTERVAL BETWEEN ONSET AND DEATH Metastatic carcinoma ca. J Prostate	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-10, 1957, to 3-12, 1957, that I last saw the deceased alive on 3-12, 1957, and that death occurred at 7:25 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. William B. Smith M.D. Medical Center Mar. 1957			
PHYSICIAN'S NAME (Type) Dr. William B. Smith		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REG'D BY REGISTRAR DATE 28 1957	
		24b. REGISTRAR'S SIGNATURE Merry H. Holloway	

PERIODIC V. S

1951 MAR 3

LIBRARY
UNIVERSITY OF TORONTO LIBRARIES
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03489

337

03489

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		d. STREET ADDRESS						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Edith M. Toadvine		First	Middle	Last	4. DATE OF DEATH March 20 1957	Month	Day	Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 14 Aug. 1872	9. AGE (In years lost birthday) 84 yrs	10. IF UNDER 1 YEAR 7 Months	11. IF UNDER 24 HRS. 6 Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Nanticoke, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.						
13. FATHER'S NAME Ward Walter				14. MOTHER'S MAIDEN NAME Alice Turner		Address Elva Toadvine, Nanticoke, Maryland						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO -----		17. INFORMANT Elva Toadvine, Nanticoke, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Arteriosclerotic Heart Disease (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nanticoke, Md.	20f. (City or town) Nanticoke, Md.	(County) Nanticoke, Md.	(State) Md.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from 15 March 1957 to 21 March 1957 that I last saw the deceased alive on 21 March 1957 , and that death occurred at 4 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Richard H. Saunders M.D.		ADDRESS Nanticoke, Md.		ADDRESS (Street, city or town, state) Nanticoke, Md.		DATE SIGNED 3/21/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/57		22c. NAME OF CEMETERY OR CREMATORIUM Turner's Cemetery		22d. LOCATION (City, town, or county) Nanticoke, Maryland		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Messick		ADDRESS Bivalve, Maryland		24a. RECD BY REGISTRAR MAR 20 1957		24b. REGISTRAR'S SIGNATURE Mary J. Holloway						

RECEIVED
MAP 1057

REAU V. S.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03490

CERTIFICATE OF DEATH

Reg. Dist. No. 332

03468

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (if outside corporate limits, write RURAL OR TOWN TOWN)		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland CITY (if outside corporate limits, write RURAL and give nearest town)		COUNTY Viocomic8 OR TOWN Berlin	
Salisbury		/		Xo		(If rural give location) Ocean City Blvd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS			
3. NAME OF DECEASED (First) DOROTHY (Middle) LEE (Last) TOWNSEND				4. DATE (Month) (Day) (Year) OF DEATH MARCH 20 th 57			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH February 6, 1925	
9. AGE last birthday 32 yrs.		10. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME A. King Powell				14. MOTHER'S MAIDEN NAME Jennie E. West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Mr. J. Russell Townsend (Husband) Ocean City Blvd. Berlin, Maryland				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cachexia</u> ANTECEDENT CAUSES (B) <u>Carcinoma of Colon Stage IV</u> DISEASES OR CONDITIONS, IF ANY, (C) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO 3 mos.				INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 17, 1956</u> , to <u>March 20, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Stedman W. Smith</u> ADDRESS (Street, city, town, state) <u>M.D. 706 Camden Ave. Salisbury, Maryland</u> DATE SIGNED <u>3/22/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 23, 1957		NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		LOCATION (City, town, or county) Powellville, Maryland	
24. REC'D BY REGISTRAR DATE MAY 10 1957		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

REFUGEE

MAR 03 1957

PAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03469

CERTIFICATE OF DEATH

03491

337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b /		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x o Hebron Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION L.H. Gen. Hospital		d. STREET ADDRESS / R.D. # 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LAURA	Middle LINE	Last Twilley
4. DATE OF DEATH	Month March	Day 2	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1937
9. AGE (In years last birthday) 0	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 3	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stanley Paul Twilley		14. MOTHER'S MAIDEN NAME Martha Frances Twilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Mr. Stanley P. Twilley (Father) R.D. # 1 Hebron, Maryland	
17. INFORMANT Mr. Stanley P. Twilley (Father) R.D. # 1 Hebron, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7/5 DUE TO Cerebral edema		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Anoxia, acute			
(c) DUE TO Chronic Fetal Anoxia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity, evidence of Placental Insufficiency		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/27, 1957, to 3/2, 1957, that I last saw the deceased alive on 3/2, 1957, and that death occurred at 10:35 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) William C. Morgan, M.D., Salisbury, Md.			
ACTUAL SIGNATURE		DATE SIGNED 3/2/57	
PHYSICIAN'S NAME (Type) Dr. William C. Morgan		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Memorial Gardens		22d. LOCATION (City, town, or county) (State) R.D. # 1 Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24e. REC'D BY REGISTRAR Holloway DATE	
		24f. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU Y. S.

MAR 7 1971

1100 1100 1100 1100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03470

CERTIFICATE OF DEATH

03492 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4½ years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Amelia	Middle (NMN)	Last Wilkinson
4. DATE OF DEATH	Month March	Day 20	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/1876
9. AGE (in years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Reynolds		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized	
		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 9, 1952, to Mar. 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 7:40 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Deer's Head State Hospital DATE SIGNED 3/20/57			
ACTUAL SIGNATURE L. V. Maldve, M. D.		PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D. BY REGISTRAR DATE MAR 26 1957	
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CHICAGO'S OWN

ILLINOIS STATE DEPARTMENT OF MIGRATION - CHICAGO

RECEIVED
BUREAU Y. S.
MAR 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

03471

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>82</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		d. STREET ADDRESS <u>819 Fourth St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23422</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred</u>		First <u>T.</u>	Middle <u>WILLIAMS</u>	Lost <u>83</u>	4. DATE OF DEATH <u>March</u>	Month <u>21</u>	Day <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>AUGUST 5 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET MEARS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>231-32-8922</u>		17. INFORMANT <u>WALTER WILLIAMS, POCOMOKE CITY, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1hr.</u>			
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>CHRONIC CONGESTIVE HEART FAILURE</u>		DUE TO (b) <u>PARTIOSCHEROTIC HEART DISEASE</u>		24 YRS.		DUE TO (c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				3-5 YRS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>3215 4th St.</u>	(County) <u>SALISBURY, MD.</u>	(State) <u>MARYLAND</u>	
21. I certify that I attended the deceased from <u>3/20</u> , 1957, to <u>3/21</u> , 1957, that I last saw the deceased alive on <u>3/21</u> , 1957, and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u>	PHYSICIAN'S NAME (Type) <u>Rufus S. Gardner, Jr.</u>	ADDRESS <u>3215 4th St.</u>	ADDRESS (Street, city or town, state) <u>SALISBURY, MD.</u>		DATE SIGNED <u>3/21/57.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING CEMETERY</u>	22d. LOCATION (City, town, or county) <u>OAK HALL</u>	22e. (State) <u>VIRGINIA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson (Pocomoke, Md.)</u>	ADDRESS <u>82</u>	24a. REC'D BY REGISTRAR DATE <u>3/27/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>				

DEPARTMENT OF HIGHWAY SAFETY

COMMONWEALTH OF MASSACHUSETTS

BUREAU V. 8

MAR 27 1957

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